eBook for academic leaders

Transitioning the nursing program to competency-based education

Lippincott® Nursing Education
by Wolters Kluwer

AACN *Essentials* facts:

45%

competencies

The Essentials sets forth 45 broad competencies that describe the skills nursing graduates must be able to demonstrate upon completion of their nursing programs.

250+

subcompetencies

Each competency is further divided into several more specific subcompetencies that clarify what the broader competency looks like in practice. The subcompetencies help programs translate expectations into measurable behaviors.

Progression indicators

Released in October 2025, progression indicators describe how competence develops through the program of study. They help nursing programs distinguish between early-stage learners and graduates ready for clinical practice. Progression indicators are not items on a checklist; instead, they reflect increasing levels of complexity, autonomy, and consistency of performance.

AACN began using *The Essentials* framework for accreditation reviews in 2025 and continues to roll out new resources and tools.

Nursing programs are increasingly expected to confirm their students are clinically competent before entering practice. Healthcare organizations seek nurses who can prioritize care for multiple patients, communicate effectively within teams, and make sound clinical decisions in fast-moving environments. Meanwhile, accreditors, practice partners, and boards are asking programs to document where those abilities are taught, how they are assessed, and how students progress through their nursing programs over time.

In response to those rising expectations, the American Association of Colleges of Nursing (AACN) publication entitled *The Essentials: Core Competencies for Nursing Education* provides a structure for making a shift in the way nurses are educated. Endorsed by member schools in 2021, *The Essentials* codifies expectations by defining 45 competencies and more than 250 subcompetencies that articulate the care activities nursing graduates must be able to do and how programs should support nursing student development.

Programs have responded positively: a 2024 AACN member survey[1] found that nearly all support full implementation of *The Essentials*, with 92% adapting or planning to adapt curricula to align with AACN competencies, and 79% designing or planning competency-based assessments. Levels of faculty readiness are also increasing: 75% of schools report that faculty possess the knowledge to implement competency-based education (CBE) at the program level.

Most programs are fully aligned with the CBE goals of *The Essentials*, but the scope of the shift can feel overwhelming. At many institutions, responsibility for *The Essentials*' alignment rests with small curriculum leadership teams. These faculty team members usually balance the new work alongside full teaching loads, leaving little time to focus on the transition to *The Essentials.*

Whether a program is in the early stages of mapping its curriculum to *The Essentials* or further along in operationalization, the goal is the same: To build a program that intentionally develops, measures, and demonstrates students' growing clinical competence through the program of study. However, revamping a curriculum to comply with *The Essentials* is not a one-and-done overhaul. Rather, it's an iterative process that will shape both your program and the next generation of nurses. Progress — not perfection — is the point.

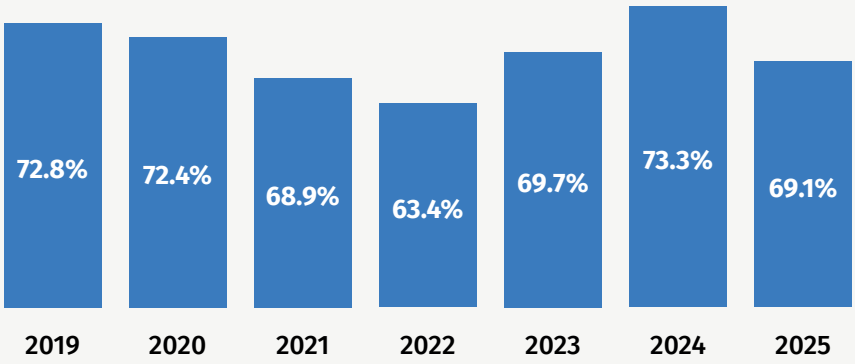
When knowledge isn't enough: The clinical judgment crisis

Since 2012, the Wolters Kluwer New Nurse Readiness Survey has tracked how well new nursing graduates fare in clinical settings. The 2020 edition[2] noted a disturbing trend: the gap between education and practice widened significantly during the 2010s in that new graduates were arriving in clinical settings unprepared for the stresses and rigors of daily practice. In fact, only 20% of employers said they were satisfied with the decision-making abilities of entry-level nurses — and half of new nurses were involved in committing practice errors.

Further research[4] by Wolters Kluwer found a widening gap between how practicing nurses and faculty viewed new graduates. Among practicing nurses, 38% found their new graduate colleagues to be completely unprepared or minimally prepared for the rigors of practice, whereas just 15% of faculty agreed. Similarly, 66% of practicing nurses said their newest colleagues were less prepared to enter practice than graduates of 5 to 10 years earlier. The COVID-19 pandemic exacerbated those readiness gaps because students had received less of the hands-on clinical practice essential to developing strong clinical judgment skills. Fluctuating scores on the National Council Licensure Examination for Registered Nurses (NCLEX-RN) reflect the struggle.

NCLEX-RN Pass Rates

Source: National Council of State Boards of Nursing[5]



Essentially, new graduates are increasingly less capable of applying their knowledge in complex care situations. And many lack the clinical judgment to manage multiple patients in evolving scenarios. In fact, one study[6] found that new-graduate nurses are especially uncomfortable independently managing codes, ventilators, and chest tubes.

Traditional nursing education has struggled to assess clinical judgment in ways that meaningfully gauge students' practice readiness. Assessment has focused on demonstrating memorized knowledge rather than how readily students can apply information to the realities of nursing practice. Even though many nursing programs acknowledge the disconnect, there was no standardized approach to intentionally develop, measure, and demonstrate students' clinical competence and decision-making abilities. That's the challenge that CBE strives to meet.

Clinical judgment remains the gap

50%
of entry-level nurses were involved in practice errors

of entry-level nurse errors were related to poor clinical decision-making

Only 20%
of employers were satisfied with decision-making abilities of entry-level nurses

Source: Wolters Kluwer New Nurse Readiness Survey, 2020[3]

What are the requirements for CCNE Accreditation?

Accreditors are not expecting perfection in your school's program in the form of a fully redesigned, operational program. Rather, they are evaluating the process through which you are overhauling your program by looking for:

- Coherence
- Alignment
- Defensible assessment methods
- Evidence of thoughtful, iterative improvement

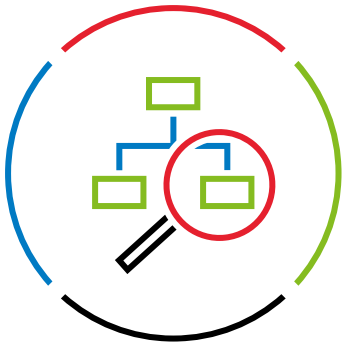
The goals of competency-based education

CBE is designed to ensure that nursing graduates are ready to practice safely, effectively, and confidently in real clinical environments. Rather than testing a student's knowledge recall at a single point in time, CBE assesses how well a student can apply that knowledge. The focus shifts from what students *know* to what they *can do* across settings, in various scenarios, and through increasing levels of responsibility. In complex healthcare systems, that shift is not optional; it is essential to ensuring graduates can translate knowledge into safe and timely clinical decisions.

In a system of CBE, competencies get sequenced throughout a curriculum, with increasing levels of context, complexity, and expectations. When a curriculum takes a scaffolded approach, students are guided to develop and demonstrate skills in more and more complicated scenarios that build on previously learned knowledge. Faculty track which competencies students have fully developed to the practice-ready level and which still need additional work.

That kind of structure aligns directly with *The Essentials*, which require nursing programs to implement competency-based models in order to retain Commission on Collegiate Nursing Education (CCNE) accreditation. By aligning outcomes, assessment, and documentation, competence no longer relies on subjective judgment. The new alignment therefore empowers faculty to build essential skills across courses by including critical thinking, prioritization, communication across teams, and clinical reasoning. It also provides a defensible framework for demonstrating how competence is intentionally measured, strengthened, and refined over time.

Where programs stall



By late 2025, an AACN survey[7] found that 92% of member schools were adapting or planning to adapt their curricula to align with *The Essentials*, and 84% of Level 1 programs had started or completed curricular mapping. About 91% planned to apply all or some of the subcompetencies in their curriculum redesigns, and half were working with their clinical counterparts to transition to CBE. But many programs reported that their biggest barriers to implementation had grown since 2022—namely, lack of time, gaps in faculty knowledge, and insufficient budgets.

Many programs stall for similar reasons:

Lack of buy-in from key stakeholders

Even when faculty are on board, CBE requires substantial buy-in from institutional partners, including deans, other college leadership, and practice partners. Gaps in institutional support can limit funding and resources.

Insufficient resources

As programs have progressed in their CBE journal, they may gain a better understanding of what the shift will take — including the financial costs. In 2022, only 29% of programs cited lack of budgetary support as a barrier to implementation; two years later 40% of programs did so.

Faculty inexperience and lack of knowledge

A large percentage of faculty lack experience in designing assessments for CBE. Senior faculty may struggle to shift from tried-and-true methods, and novice faculty may lack the experience to create CBE structures and processes.

Time commitment

Adjusting to AACN expectations and meeting CCNE accreditation standards can feel overwhelming — especially when the goalposts are fluid. Since the initial 2022 survey, those citing faculty time as the top barrier to implementation have surged from 56% to 83% of programs.

Top barriers to implementing *The Essentials*	Fall 2022	Fall 2024
Lack of faculty time or commitment to work on the implementation process	56%	83%
Lack of faculty knowledge	40%	61%
Lack of budgetary support	29%	40%

Source: AACN 2024 survey[8]

When an outside perspective can help

If your program transition has stalled, professional organizations and peer networks may help exchange ideas, compare approaches, and validate decisions. Even mature programs can benefit from an outside perspective when preparing for accreditation review.

Many programs partner with experienced nurse educators who specialize in competency-based curriculum design and accreditation alignment to bring this structure and perspective to their teams. An experienced nurse educator can help you:

- Distinguish required elements from recommendations
- Sequence the work realistically
- Optimize competency bundling to reduce faculty burden
- Strengthen alignment between outcomes, assessment, and documentation
- Identify blind spots before they surface during accreditation

A framework for implementing CBE

CBE is best understood as having a maturity cycle in the form of a framework that follows development from concept to growth, with ongoing iteration that continues to improve the process. Typically, a program sequences implementation in three distinct stages. It begins by diagnosing how well the current curriculum aligns with the new competencies. Then it architects alignment between curriculum and assessment. And finally, it operationalizes the program to scale over the program of study. Understanding your program's current stage can serve to clarify priorities, chart next steps, and reduce overwhelm.

STAGE 1	STAGE 2	STAGE 3
Governance and diagnostic alignment *Mapping competencies*	**Curriculum architecture and assessment design** *Alignment and redesign*	**Operationalization and continuous improvement** *Embedding and scaling*
Appoint an implementation lead with accountability	Design scaffolding to support competency teaching and reinforcement	Standardize documentation and reporting
Conduct a structured curriculum gap analysis	Rewrite program and course outcomes via measurable behaviors	Embed program indicators across evaluation tools
Establish shared fluency in CBE language	Group competencies and subcompetencies into integrated bundles	Continue structured faculty development
Define the strategic reason for transition to CBE	Align assessments to subcompetencies	Formalize alignment with practice partners
Obtain stakeholder commitment	Embed progression indicators into evaluation rubrics	Implement formal feedback and continuous-improvement loops
Secure budget and operational resources		
Map current curriculum as it may align to AACN competencies		

Mapping competencies

Most programs begin their CBE journey by establishing a committee and seeking to understand *The Essentials*. Many begin by conducting a gap analysis to systematically compare the existing curriculum against *The Essentials* competencies, an effort that can surface misalignment and highlight areas that require focused efforts. Many programs get stuck after the gap analysis because they have missed one of three key steps:

1

Establish the why

First and foremost, programs should pause and clarify their why. CBE is more than an accreditation to-do. It should reflect each program's mission and values and the needs of practice partners and the community.

Action:

Host a workshop with key stakeholders — faculty leaders, clinical partners, and senior administration — to align expectations and establish shared direction.

2

Clarify confusion about competencies, subcompetencies, and progression indicators

Getting the entire faculty on board and speaking the same language are vital before moving forward. This clarification calls for discussing internally as a team as well as learning from external experts.

Action:

Take advantage of external resources to learn how others are implementing CBE. As of late 2025[9], 88% of programs reported that faculty had attended at least one CBE workshop — and 68% said the materials and information were significantly useful for implementing subcompetencies.

3

Identify a champion

Without clear ownership, even well-designed plans stall. A defined leader or a small core team can better maintain momentum, delegate responsibilities, and celebrate progress across the program. The champion should regularly communicate milestones, reemphasize direction, and restate needs to stakeholders.

Action:

Designate a leader who has strong working relationships with senior leadership, faculty, and practice partners. The ideal leader will also have budgetary and decision-making authority to ensure work progresses.

As of late 2024, AACN data[10] show significant improvement in curricular alignment among Level 1 programs:

84%
had started or completed mapping to *The Essentials*.

32%
had developed an organizational structure to support implementation — up from 23% in 2022.

34%
had submitted curricular revisions for approval.

Aligning and redesigning the program

Once the entire team has a shared understanding of the AACN nomenclature, direction, and initial competency mapping and gap analysis, it's time to build the architecture that will start aligning outcomes, assessments, and learning experiences. Revisiting the complete program through a competency lens begins moving from simple content coverage to ensuring that student performance is measurable; such revisiting is vital to support the defensible assessment required by AACN, and it requires careful attention to structure and detail.

Many programs adopt a structured, or scaffolded, approach that sequences learning experiences so that students encounter each competency and subcompetency several times, with increasing complexity.

Best practice

A scaffolded approach to CBE supports students as they move through the program and develop more clinical judgment and autonomy:

- **Introduce** each competency and subcompetency
- **Reinforce** the knowledge and application through repeated exposure
- **Master** each competency across contexts by demonstrating clinical judgment

With scaffolding in place, curriculum design becomes more manageable. Instead of mapping each competency and subcompetency independently — which may quickly begin to feel overwhelming — logical bundling of related competencies enables faculty to teach and assess clusters of skills in ways that mirror real-world practice, where competencies rarely exist in isolation. This reinforcement strengthens student competence and reduces fragmentation.

Once bundling is complete, the next step is to define observable behaviors — which AACN calls *progression indicators* — and integrate them into rubrics. This defining enables programs to document student progression over time. Many programs encounter significant friction at this step — especially when clinical evaluation tools vary from instructor to instructor.

Shifting from broad descriptors to measurable behaviors requires clarifying what so-called developing competence looks like compared to fully developed competence at graduation. To track that growth, students should encounter and demonstrate each competency in multiple contexts throughout the program, ensuring assessments are intentionally aligned with outcomes.

With these elements in place, programs can take a backward-design approach and revise courses to focus on the things students will be able to *do* with their knowledge. As such, curriculum scaffolding may occur as faculty:

• Rewrite outcomes to clearly identify the desired results

• Determine acceptable evidence and how to assess it

• Plan instruction and learning experiences that will achieve and document those outcomes

Embedding and scaling

With a strong structure, a program can begin to fully operationalize CBE. By documenting examples of student progression from faculty and clinical partners, a program can further refine its curriculum while scaling across each student's entire educational journey. Embedding progression indicators and tracking at the subcompetency level monitors each element while providing the flexibility to adapt to changes in accreditation and program needs.

At this stage, alignment with practice partners is especially important because practice partners can provide useful outside perspectives. The program should ensure that the partners are versed in the progression indicators and should collect regular, constructive feedback. Each program should have a mechanism for gathering, reacting to, and incorporating this input from key stake holders, including partners, faculty, and students.

Beyond sharing their feedback, faculty should continue developing their own teaching through ongoing education. A program should provide ample opportunities for faculty to innovate and share new teaching or assessment strategies. Encouraging mentorship and peer learning through a culture of collaboration elevates both faculty skills and program outcomes.

Stage	You may be here if	Next tactical steps
Diagnose	Your team is still working primarily in spreadsheets There's confusion about which competencies are covered by courses Subcompetencies feel overwhelming or fragmented Leadership support exists, but ownership is unclear Meetings focus on interpreting AACN language rather than redesigning the curriculum You have identified gaps but have established no next steps Little documentation language has been drafted for accreditation review	Appoint a champion Move from spreadsheet mapping to competency bundling Prioritize what must happen now versus later Identify two or three priority domains to pilot alignment
Architect	Program outcomes have been revised to reflect competency language Curriculum revisions have been submitted Competencies are bundled into logical groupings Faculty are revising syllabi to include measurable behaviors Assessment tools are being redesigned and piloted to align with subcompetencies Documentation processes are emerging but not yet standardized Faculty meetings focus on assessment alignment You are debating how to define developing versus developed	Rewrite outcomes by using measurable behaviors Align two or three assessments to subcompetencies Embed progression indicators into evaluation tools Draft documentation language for accreditation reports
Operationalize	Subcompetencies are embedded throughout the curriculum Progression indicators are integrated into evaluation tools Practice partners understand and reference competency language Faculty use shared rubrics and evaluation templates Documentation language is consistent between courses and accreditation materials You can demonstrate student progression across semesters Faculty are innovating within the framework Competency tracking survives faculty turnover without disruption	Standardize assessment language Train clinical partners on progression indicators Build reporting cadence Collect structured faculty, partner, and student feedback Schedule annual curriculum refinement cycles

How to measure and demonstrate improvement: The three things that matter most to accreditors

Measurement is a key point in CBE and represents an enormous shift from traditional education models. By focusing on the metrics that matter most, programs can focus their tracking so the right information is readily shareable with accreditors and other stakeholders.

1 Demonstrable student progression

Rather than measuring students via course grades, the goal now is to demonstrate *how* students progress and develop skills through the course of their education. CBE depends on demonstrating that progression through the program of study.

- **Ask:**
  Can you clearly show how a student's clinical judgment skills grow through time?
- **Track:**
  - Progression from developing to proficient, to practice readiness
  - Multiple assessments of the same competency through time
  - Evidence of improvement after feedback and/or remediation
  - Trends across classroom, simulation, and clinical settings

2 Coherent, aligned measurement

Simply mapping subcompetencies is not sufficient for accreditors who expect to see a defensible, well-thought-out structure. Accreditors expect well-documented, measurable alignment throughout a curriculum.

- **Ask:**
  Are all parts of your curriculum measured by the same terminology?
- **Track:**
  - Percent of assessments mapped to AACN subcompetencies
  - Use of observable, measurable behaviors in rubrics and assessments
  - Consistency in how competence is defined and how it gets documented across classroom, simulation, and clinical

3 Evidence of iterative improvement

Accreditors want to see proof of evolution, not perfection. Demonstrating improvement is impossible without tracking outcomes through time, showing what changed, and explaining how feedback was applied.

- **Ask:**
  Can you show how your program has improved — and why?
- **Track:**
  - Curriculum adjustments based on performance and feedback
  - Feedback loops from faculty and clinical partners
  - Clear rationales for changes

Leadership and governance for stronger faculty engagement

Faculty resistance is rarely about opposition to CBE. More often, it reflects exhaustion, uncertainty, or fear of new work getting added into already strained workloads. Newer faculty often step into leadership roles without prior experience in accreditation cycles or extensive curriculum revision. Even experienced program leaders may be daunted by the volume of subcompetencies and the shifting goalposts.

CBE succeeds when faculty are supported with clear structure, a realistic road map, and shared purpose. Engagement levels increase when faculty see visible leadership commitment. Leadership commitment takes not just approval but also active participation, vigorous advocacy, and extensive effort. Those who lead implementations must have clear decision authority and regular communication with academic leadership, and they must have sufficient resources.

Faculty also need clear governance by a well-defined road map. When everyone knows what comes next, what elements are expected, and why these key elements are important, they become more collaborative — even when things are hard. Newer faculty benefit from additional structure and mentorship, especially if they have never been through a curriculum redesign. Channel their enthusiasm with explicit expectations to reduce their anxiety about “getting it wrong.”

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Conclusion: Progress, not perfection

CBE has no finish line. It is a shift in the ways nursing programs define, develop, and demonstrate competence through the program of study, with a mission to develop the next generation of practice-ready nurses. *The Essentials* is not a simple compliance exercise. It stipulates expectations for the things practice-ready nurses must be able to do within increasingly complex clinical environments.

Remember that accreditors are evaluating whether you have built a coherent system that intentionally develops competence, measures progression, and improves iteratively to further elevate your school's nursing program. With time, alignment with CBE will go beyond accreditation and will serve to strengthen student confidence, reinforce faculty cohesion, and amplify your program's reputation.

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